

conditions specified in paragraph (b)(2)(i) of this section.

(3) *Application: Payment on a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(3)(ii) of this section, the costs incurred by the HCPP are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in subpart E of part 405 of this chapter; and

(B) The amount that CMS would pay for those services if they were furnished to beneficiaries who are not enrolled in the HCPP and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the paragraph (b)(3)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In these cases, the amount paid by an HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993]

#### § 417.804 Cost apportionment.

(a) The HCPP follows the cost apportionment principles specified in §§ 417.552 through 417.566, except for provisions on provider costs and provisions on departmental apportionment.

(b) The HCPP may use a method for reporting costs that is approved by CMS. CMS bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

#### § 417.806 Financial records, statistical data, and cost finding.

(a) The principles specified in § 417.568 apply to HCPPs, except those in paragraph (c) of that section.

(b) The HCPP may use a method for reporting costs that is approved by CMS. CMS bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(c) An HCPP must permit the Department and the Comptroller General to audit or inspect any books and records of the HCPP and of any related organization that pertain to the determination of amounts payable for covered Part B services furnished its Medicare enrollees. For purposes of this requirement, the principles specified in § 417.486 apply to HCPPs.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993]

#### § 417.808 Interim per capita payments.

The HCPP follows the principles specified in §§ 417.570 and 417.572 on interim per capita payments, except for the following:

(a) When applying these principles to HCPPs, the term "reporting period" should be used instead of the term "contract period" contained in that section.

(b) An HCPP must submit to CMS an annual operating budget and enrollment forecast, in the form and detail specified by CMS, at least 60 days before the beginning of each reporting period. A reporting period must be 12 consecutive months, except that the HCPP's initial reporting period for participating in Medicare may be as short as 6 months or as long as 18 months.

(c) An HCPP must submit to CMS an interim cost report and enrollment data applicable to the first 6-month period of the HCPP's reporting period in the form and detail specified by CMS. The interim cost report must be submitted not later than 45 days after the close of the first 6-month period of the HCPP's reporting period.

(d) In lieu of an interim payment based on the actual monthly enrollment in an HCPP, CMS and the HCPP may agree to a uniform monthly interim reimbursement rate for a reporting period. This interim rate is based on the HCPP's budget and enrollment forecast, if CMS is satisfied that the rate is consistent with efficiency and

economy, and will not result in excessive adjustment at the end of the reporting period.

**§417.810 Final settlement.**

(a) *General requirement.* CMS and an HCPP must make a final settlement, and payment of amounts due either to the HCPP or to CMS, following the submission and review of the HCPP's annual cost report and the supporting documents specified in paragraph (b) of this section.

(b) *Annual cost report as basis for final settlement—*(1) *Form and due date.* An HCPP must submit to CMS a cost report and supporting documents in the form and detail specified by CMS, no later than 120 days following the close of a reporting period.

(2) *Contents.* The report must include—

(i) The HCPP's per capita incurred costs of providing covered Part B services to its Medicare enrollees during the reporting period, including any costs incurred by another organization related to the HCPP by common ownership or control;

(ii) The HCPP's methods of apportioning costs among its Medicare enrollees, enrollees who are not Medicare beneficiaries, and other nonenrollees, including Medicare beneficiaries receiving health care services on a fee-for-service or other basis; and

(iii) Information on enrollment and other data as specified by CMS.

(3) *Extension of time to submit cost report.* CMS may grant an HCPP an extension of time to submit a cost report for good cause shown.

(4) *Failure to report required financial information.* If an HCPP does not submit the required cost report and supporting documents within the time specified in paragraph (b)(1) of this section, and has not requested and received an extension of time for good cause shown, CMS may—

(i) Regard the failure to report this information as evidence of likely overpayment and reduce or suspend interim payments to the HCPP; and

(ii) Determine that amounts previously paid are overpayments, and make appropriate recovery.

(c) *Determination of final settlement.* Following the HCPP's submission of

the reports specified in paragraph (b) of this section in acceptable form, CMS makes a determination of the total reimbursement due the HCPP for the reporting period and the difference, if any, between this amount and the total interim payments made to the HCPP. CMS sends to the HCPP a notice of the amount of reimbursement by the Medicare program. This notice—

(1) Explains CMS's determination of total reimbursement due the HCPP for the reporting period; and

(2) Informs the HCPP of its right to have the determination reviewed at a hearing in accordance with the requirements specified in §405.1801(b)(2) of this chapter.

(d) *Payment of amounts due.* (1) Within 30 days of CMS's determination, CMS or the HCPP, as appropriate, will make payment of any difference between the total amount due and the total interim payments made to the HCPP by CMS.

(2) If the HCPP does not pay CMS within 30 days of CMS's determination of any amounts the HCPP owes CMS, CMS may offset further payments to the HCPP to recover, or to aid in the recovery of, any overpayment identified in its determination.

(3) Any offset of payments CMS makes under paragraph (d)(2) of this section will remain in effect even if the HCPP has requested a hearing in accordance with the requirements specified in §405.1801(b)(2) of this chapter.

(e) *Tentative settlement.* (1) If a final settlement cannot be made within 90 days after the HCPP submits the report specified in paragraph (b) of this section, CMS will make an interim settlement by estimating the amount payable to the HCPP.

(2) CMS or the HCPP will make payment within 30 days of CMS's determination under the tentative settlement of any estimated amounts due.

(3) The tentative settlement is subject to adjustment at the time of a final settlement.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993; 73 FR 30267, May 23, 2008]

**§417.830 Scope of regulations on beneficiary appeals.**

Sections 417.832 through 417.840 establish procedures for the presentation